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Determinants of Latinx Patients' Perceptions of Trust in their Physicians at the Primary Health Care Level

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by

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Abstract

This study examines the predictors of Latinx patient's trust in their primary healthcare providers. Specifically, this study tests patient and physician characteristics that contribute to feelings of trust in the healthcare setting. Latinx adults from primary care clinics in Southern California and a legal aid office in Canton, Ohio, completed surveys on their perceptions of cultural sensitivity, compassion, and communication received from their physicians in addition to overall feelings of trust toward their physicians. Surveys also asked participants about their language preference, generational status, and demographics. Data was analyzed using a linear multiple regression model with trust as the dependent variable. The results indicate that physician's compassion and patient's age are significant predictors of the level of trust Latinx patients have toward their physicians. The finding on compassion can inform physician training for the future and shape Latinx patients' experiences in healthcare within the United States, fostering an environment of trust.

Keywords: Health, Primary Care, Trust, Latinx Population

Healthcare, like food and water, is a basic necessity. Healthcare has constantly been a topic of discussion and debate in the social and political arenas (Thom et al., 2004). The questions of who does and should have access to primary healthcare, what are the economic ramifications of expanding access, and who will benefit from such changes are just a few topics that are important to consider when examining the impact primary healthcare institutions can have in communities.

The United States has an unfortunate history of discrimination and mistreatment of minority populations within the health field, which continue to have negative effects on patient adherence to treatment and inherent trust in the healthcare system as a whole (Stewart et al., 2007). Evidence of the neglect and discriminatory actions in the healthcare system toward people belonging to ethnic minorities is jarring. For example, the United States government told black men that they were receiving free health care in the Tuskegee syphilis experiments, formally known as the Tuskegee Study of Untreated Syphilis in the Negro Male. In reality these men, some of whom had contracted the disease, were left untreated and scientists withheld knowledge of the disease and its cure, penicillin, from them for 40 years (Nix, 2017). Yet another example of mistreatment was the 40-year U.S. government-funded sterilization program of women in Puerto Rico, where sterilization was the only form of birth control offered to women and many were left regretting the decision after being misinformed about its permanent effects (Andrews, 2017). Even today, the damaging effects of discrimination in healthcare can have deadly consequences. For instance, the maternal death rate in the United States is higher than in any other developed country; patients of color are three to four times more likely to die from childbirth or related complications than non-Hispanic white women (Chalhoub and Rimar, 2018). It is important to study levels of trust patients feel toward their doctors and clinicians

given the historical context of patient care, particularly among minority populations like the Latinx community, which is the largest and fastest-growing racial/ethnic minority group in the United States (Villatoro et al., 2016).

Keeping in mind that the Latinx community now makes up about 17% of the country's population, it is necessary to make resources available and inclusive (Villatoro et al., 2016). Understanding that cultural and linguistic differences exist and that there are preconceive notions in how the Latinx community is perceived may have an impact on how healthcare providers treat Latinx patients. This culturally sensitive approach can also affect how patients feel toward their providers. Research suggests that mental health needs in the Latinx community are more likely to go untreated than for those who belong to the majority population and that they are three times more likely to drop out of treatment prematurely (Villatoro et al., 2016; Bridges et al., 2014).

This study will examine patient perceptions of cultural sensitivity, compassion, and communication received from their healthcare providers and measure overall feelings of trust related to patient care in a community where the minority population is primarily Spanish-speaking. As a result, this research aims to shed light on the issue of disparities in healthcare and the importance of representation and relatability in health and mental health care. Findings from this study may be able to give primary care clinics a clear idea of whether their services are being received positively and whether there are areas of patient care that would benefit from improvement.

Trust

Healthcare is delivered by people for people. It is a system that functions through human interaction, so it is important to consider the role that relationships play in creating a functioning and effective healthcare system. Generally, the individual seeking treatment is putting their faith

in a complete stranger, allowing that professional to care for them and be informed of the inner-workings of their life and potential struggles. With that type of vulnerability, the patient has certain expectations of what is to come from that relationship. For example, effective communication, a genuine interest and concern for that person as an individual, and an understanding of that person's background and values are essential. These expectations, in tandem, work together to establish what is likely the most important aspect of a patient-provider relationship: trust (Ozawa & Sripad, 2013). A person who trusts a provider is more likely to seek care, adhere to treatment recommendations made by the provider, and return for follow-up care (Alegría et al., 2013; Ozawa & Sripad 2013; Thom, Hall & Pawlson, 2004). Collecting and analyzing data on how the presence of trust impacts the patient-provider relationship may provide the formal structure healthcare institutions need in order to address potential systemwide failings or communication issues, improving overall trust as a result (Thom, Hall & Pawlson, 2004). Improved trust can have positive implications such as reducing healthcare disparities, increasing access, and improving overall health outcomes (Thom, Hall & Pawlson, 2004).

Trust can be defined in many ways, but at the most universal level, trust is the acceptance of a vulnerable situation in which an individual believes that another will act in that individual's best interests (Thom, Hall & Pawlson, 2004). More specifically, trust is when providers demonstrate "interpersonal and technical competence, moral comportment, and vigilance to support positive patient outcomes" (Murray & McCrone, 2014, p. 4). Trust is often a defining characteristic of patients' relationships with their providers because these relationships are exceedingly personal and even life-altering. Trust is considered as part of the "collective good" that is essential for an effective healthcare system, much like one might say for the importance of

freedom for the functioning of an effective United States government (Thom, Hall & Pawlson, 2004).

Trust and satisfaction have been studied as interchangeable concepts, but satisfaction has more to do with patients' experiences in past situations, while trust is based more on an expectation of future behavior (Fuertes et al., 2006). Trust is based on perceptions of an individual's motivations towards another and has a very strong emotional component that is not present in satisfaction. In essence, a patient can feel satisfied with their treatment and ongoing relationship with their provider, but trust is that additional factor that reflects a deeper commitment and established sense of comfort with their provider. Additionally, it is possible for patients to feel unsatisfied after a single appointment but still maintain that established sense of trust with their provider (Thom, Hall & Pawlson, 2004). This established relationship of trust that patients feel with their providers has an impact on their feelings toward and disclosure to medical professionals, people who they should be able to confide in about the details of their health and wellbeing in order to receive the best care possible. As such, patient-centered care is a primary focus in health settings.

Patient-centered care has emerged as a key approach in health settings. This form of care addresses the need for a broader, more comprehensive model of care that incorporates patients' biological, psychological, and cultural factors (Fuertes et al., 2006). Additionally, patients' overall feelings of trust in their providers and/or the healthcare system have been examined in order to further analyze the larger question of how to provide the best, most inclusive care possible (Fuertes et al., 2006). For overall patient care, there appear to be fundamental characteristics that are important for the patient with regard to their feelings of trust in a healthcare setting. The basic human need for connection during a time of considerable stress, or

what some describe as the "connexional dimension of medical care," is something that patients tend to seek out in their relationships with their physicians (Fuertes et al., 2006, p.30).

A vital component of a patient's perceptions of the healthcare system involves how connected they feel to the medical professional and how much they perceive that their doctor cares about them and their physical and emotional health needs. This type of effective, trust-promoting and patient-centered treatment presents itself in a few key ways. When present, patients are able to play an active role in their own care, can establish and have open communication with their physicians, have a history of fulfilled trust, and feel that the physician works to reduce power differences by responding to the patient's self-disclosures in a positive and nonjudgmental manner (Fuertes et al., 2006; Ozawa & Sripad, 2013; Thom, Hall & Pawlson, 2004). When patients can see these positive patient-provider relationship characteristics, they are more likely to see the value of the treatment or medical advice being given and even more likely to put their health in their own hands, complying with advice or regimens prescribed by their physicians (Fuertes et al., 2006).

Trust is also influenced by "patient activation," a concept that focuses on the importance of communication and understanding in a working relationship (Alegría et al., 2009). Patient activation is the principle defined as the communication relationship between patient and physician that acts as a signal to patients that their opinions are valid and important to their physician, and that a collaborative relationship exists between patient and physician (Alegría et al., 2009). Patient activation is positively related to perceived quality of care and enhanced doctor-patient communication among the Latinx population (Alegría et al., 2009). Patient activation and patient alliance are closely related, with both concepts focusing closely on the necessary components to a healthy and successful physician-patient relationship like

communication and shared understanding of ideas and treatment plans (Fuertes et al., 2006). This concept is particularly important to examine when considering the Latinx population, just as with any other minority group, because of the unique needs and potentially differing perceptions of care and communication toward patients from different backgrounds. As an ethnic minority, having that patient activation for the Latinx population could greatly enhance the relationship between patient and healthcare system.

Latinx Population

The health needs particular to minority populations are especially useful for the healthcare provider to consider because they may vary in unexpected ways. There are several negative implications for lack of trust in the patient-provider relationship, particularly among people of color. Patients report lower levels of trust with their providers, which consequently may explain their lower rates of care seeking, preventive services, and surgical treatment as compared to whites (Thom, Hall & Pawlson, 2004; Ojeda & Bergstresser, 2008).

Patients with a decreased sense of trust in their providers have a lower likelihood to adhere to treatment prescribed by their doctor in both the primary care setting as well as the behavioral health setting (Bridges et al., 2014; Thompson & McCabe, 2012). Attending to the unique needs of ethnic minority groups, like the fast-growing Latinx population, in all areas of the healthcare setting is essential. As important as it is to attend to the physical health needs of patients belonging to this group, it is equally as important to be aware of how the physical needs could translate to the behavioral and mental health needs of these same patients. Physical ailments can have a negative effect on the mental health of patients, and it is important that medical professionals be prepared to address both in a manner that is easy for the patient to understand as well as to promote increased levels of trust patients feel towards their doctors.

These factors of patient trust in a health setting apply to all patients, but because the needs of minority patients are often overlooked, examining how to expand culturally inclusive care is necessary. There is a growing need for healthcare professionals to consider and be better prepared to address the mental health needs of Latinx patients. The Latinx population is continually expanding and currently makes up about 17% of the entire population in the United States (Villatoro et al., 2016). Overall, the prevalence of mental health issues presenting themselves among the Latinx population is lower or equal in comparison to non-Latinx whites (Bridges et al., 2013; Villatoro et al., 2016). However, there is a likelihood that mental health needs in the Latinx population are disproportionately greater than what research suggests because they often go undiagnosed and untreated. They are less likely to receive adequate health care in comparison to the majority population (Bridges et al., 2014; Villatoro et al., 2016). In actuality, approximately 60% of Latinx patients "meet lifetime diagnostic criteria for any mood, anxiety, or substance use disorder" (Villatoro et al. 2016, p.93).

Although the mental health needs of the Latinx population are multifaceted, their participation in mental health services is lower than that of the general population. The majority of Latinx individuals who have the greatest need for mental health services do not seek that care: 64% of the U.S. Latinx population versus 40% of non-Latinx Whites do not use any form of mental health services (Villatoro et al., 2016). The utilization of these services by the Latinx population translates to perceptions of care and feelings of trust in a system that has proven to lack adequate resources for their needs as a minority population. Behavioral health providers should be aware of their patient demographics in order to administer the best, most appropriate care possible. In communities where the majority minority population is Latinx, which is the case for many places across the United States, it is vital that these patients feel that their

providers are taking the time to understand who they are and where they are coming from, and have a genuine interest in them as a person. There are two characteristics among Latinx patients that have an impact on how they interact with the healthcare system and the professionals who treat them. A patient's language preference along with their generational status play a role in not only their interactions with healthcare professionals and within the larger healthcare system, but also their feelings and perceptions of how they are being received and the quality of their treatment.

Language. Language is a key factor that influences patient perceptions of trust toward their providers, particularly among the Latinx community. When patients are able to understand the course of action a doctor is taking and can be actively engaged in that process, the result is increased patient-provider communication and overall quality of care (Alegría et al., 2009). Language, then, is directly linked to the quality of the physician-patient relationship. An improved relationship, or even perception of a relationship, can be found when the patient believes that their provider is taking a genuine interest in their needs and clearly communicating those needs with them, consequently improving trust. The level of trust Spanish-speaking parents felt towards their child's physician increased after the physician had completed a two-week Spanish language immersion course (Thom et al., 2004).

For Latinx patients, many come to the health setting with Spanish as their primary language, and there may or may not be resources available to them in their primary language, which can pose difficulties when trying to navigate unfamiliar settings (Bridges et al., 2014). Because communication is so key to providing healthcare, a doctor's adaptability to language needs can have a large impact on a patient's feelings of trust. Trust may not even be the only impacted outcome. Adherence and satisfaction, for example, have an important role in patient

success. Patient satisfaction and treatment adherence are two variables that have been measured extensively to comprehend the complexity and success of a provider-patient working relationship (Thom, Hall & Pawlson, 2004).

When patients are ethnically and linguistically matched with their providers, there are better results for adherence, especially for Black and Latinx minority populations (Bridges et al., 2014). This is not difficult when both patient and provider belong to the dominant, majority population, but can pose issues when there are no providers available who either have the same ethnic background or can speak the same language as their patients. With regard to behavioral health treatment, being able to speak the same language as the professional who is treating the patient is an essential component to establishing trust (Bridges et al., 2014). Sharing personal, often difficult information with a provider can be burdensome when there is an added language barrier and lack of understanding. For many patients, it is already emotionally taxing to be vulnerable and share details and struggles of their personal lives, but when the two parties are unable to effectively communicate, the quality of care received may be compromised.

A language mismatch between doctor and patient can also have obvious impacts like miscommunication and misunderstanding of shared information. The interaction between a Spanish-speaking patient who is attempting to communicate with their doctor who only speaks English may get misconstrued due to the language barrier, thus leading to adverse effects on the patient's health and understanding of their treatment plan. Not all health settings have the resources for a translator or interpreter, and when this is the case, information is likely to get lost. If there is such misunderstanding, research suggests that trust may be the factor in the physician-patient relationship that gets compromised, having an effect on how comfortable patients feel

sharing sensitive information with their doctors (Alegría et al., 2013; Bridges et al., 2013; Lê Cook, Brown, Loder, & Wissow, 2014).

Generational status. In addition to language, generational status may provide an explanation for the stress that Latinx individuals feel and why they seek care, potentially acting as a push-factor into mental health treatment. Generational status refers to the place of birth of an individual or the individual's parents. First-generation individuals are those who were born in another country and have immigrated to the host country. Second-generation individuals are those who were born in the host country but have at least one parent who immigrated to the host country. Third-generation individuals are those who have at least one grandparent who immigrated to the host country and a parent who is a second-generation immigrant. An additional level to this breakdown of generational status is the 1.5- generation immigrant, meaning the individual immigrated to the host country at a very young age. Generational status has an impact on feelings of trust toward the healthcare system and those associated with this system, particularly in behavioral health. After someone has immigrated, the amount of time spent in their host country determines their generational status. Patients who are first-generation immigrants are likely to have different physical and mental health needs as compared to second- or third-generation immigrants.

The "healthy immigrant" effect within mental health suggests that second and third generation Latinos are more at-risk of any lifetime psychiatric disorder than first generation Latinos; this effect is most apparent among Mexican immigrants (Calvo & Hawkins, 2015). According to this concept, those who have long residency in the United States or have immigrated at a young age are more at risk of having a mental disorder than those who have resided in the United States for a shorter period of time or who immigrated later as an adult

(Calvo & Hawkins, 2015). This idea is closely related to the "immigrant paradox," a phenomenon whereby second- and later-generation immigrants fare worse in a variety of outcomes (e.g., academic, social, health) than first-generation immigrants do. For most immigrant groups, length of residence in the United States is associated with a decline in physical and psychological health (Suárez-Orozco, Pimentel & Martin, 2009). It seems counterintuitive that those who have had longer residency in the host culture, and thus more time to acculturate, would be more likely to suffer from mental illness. So, in understanding that lifetime mental disorders are more prevalent among second- and third-generation Latinos, providers must consider that care may need to be tailored to address the needs of a unique population that does not fit into the traditional mold for the typical cultural, ethnic, or linguistic differences (Calvo & Hawkins, 2015; Villatoro et al., 2016).

Generational differences can have an impact on how individuals acculturate to their host cultures. The process of moving and adapting to a new culture in a new country can cause acculturative stress, the reduction in mental health and wellbeing of ethnic minorities (Lueck & Wilson, 2010). Acculturation is the process of negotiating social and cultural norms between two or more cultures, typically including that of the individual's country of origin and the host culture (Sirin et al., 2013). Acculturative stress, which refers to the potential challenges immigrants face when negotiating differences between the two cultures, can vary depending on the level of differences between the ethnic and host culture (Sirin et al., 2013). Variables that impact the level of stress ethnic minorities and immigrants may feel include preferences for social customs and language, age at the time of migration, current age, years of residence in the host country, ethnic networks, and perceptions of prejudice, which are all factors that have been mentioned previously as having an effect on a patient's perceptions of trust in their physicians

within the healthcare system (Lueck & Wilson, 2010). Acculturative stress can lead to depression, anxiety, increased incidences of somatic complaints, and decreased self-esteem (Sirin et al., 2013). Levels of acculturation make an impact on how individuals interact in healthcare, and a doctor's understanding that less acculturated individuals feel more acculturative stress may aid in providing more appropriate care for their patients.

These patient characteristics play a significant role in how Latinx patients feel about seeking and utilizing care as well as what they may expect from their providers to encourage a positive experience. Immigrants may enter the U.S. context for healthcare with preconceived perceptions of what to expect from their doctor and what healthcare looks like based on personal experiences from their country of origin. In some cases, particularly for first-generation immigrants, it may even be that interacting with healthcare in any regard is indicative of poor health and illness with no hope of being treated back to health. However, these perceptions may not persist throughout the later generations. Because second- and third-generation immigrants have had time to acculturate and experience the culture of the U.S. healthcare system, they may feel differently in terms of their personal perceptions of trust in not only their physician, but in the healthcare system as a whole than first generation immigrants. If this is the case, generational status has the potential to play a significant role in patients' overall feelings of trust in their doctors. In addition to these patient factors, however, are physician factors that impact how patients perceive the level of trust with their physicians.

Physician Factors Predicting Trust

Patient factors are not the only influences on patient perceptions of trust in their provider and in the healthcare field in general. Particularly for minority populations, like Latinx patients, there are certain factors like language and generational status that have an impact on their

interactions and sentiments toward their providers. There are also key factors and skills that play a role in physicians' interactions with their patients. The physician factors that can predict patient trust that this study will investigate are the physician's communication style and skill, their compassion, and their cultural sensitivity.

Communication. What a physician says and does can have a profound impact on a patient's engagement, adherence, and overall trust in their doctor. Communication refers to the aspects of the behavioral exchange between physician and patient, describing and relating information either subjectively or objectively, or as will be described later, information giving and collaboration. Almost as important in the long-term as what the doctor prescribes or advises is the manner in which they interact with and speak to their patients (Thompson & McCabe, 2012). Particularly in mental healthcare, patient-centered communication is effective in promoting a positive space for growth and effective treatment. Collaborative communication and the inclusion of the patient's perspective in shared decision making, particularly for treatment options, have proven to be critical components in policy for mental health (Thompson & McCabe, 2012). Previous research indicates that patients rarely state their concerns during a medical visit and typically refrain from being actively engaged in information-seeking behavior. Among the patients that do seek information, provider communication of treatment plans and information given is minimal, with physician's underestimating their patients' desire for information (Alegría et al., 2013). These problems of a lack of patient engagement and potential feelings of intimidation in addressing specific health-related concerns with their doctor can be addressed by analyzing the benefits of patient-centered care.

Patient-centered care, focusing on the importance of patient activation to the satisfaction and enhanced care of patients, is vital. Many institutions and researchers have examined this

topic by determining how provider-inspired patient activation affects health outcomes of patients with chronic diseases, but few have examined it for particular populations like the Latinx population (Alegría et al., 2013). In these groups where the patient is in a weakened or vulnerable state, either physically, mentally or socioculturally, they are even more dependent on their physician to provide them with sound treatment options and to build a trusting relationship with them (Holwerda et al., 2012). A physician's judgment about treatment options is important and for them to be able to both have that professional knowledge and to effectively communicate that knowledge are essential. A violation of this relationship that has been built can lead to significant consequences for both the provider and the patient. There is a wide and reputable consensus for patient-centered communication due to its ability to yield improvements on outcomes in physical and mental health and be ethically creditable. A physician who communicates effectively takes steps to reach a consensus about treatment, accounting for the patient's preferences. By utilizing these strategies, it is expected that patient self-determination will increase and in turn, have a positive effect on treatment adherence (Thompson & McCabe, 2012).

The Health Communication Model sets standards for physician communication. Fundamental elements of physician initial and follow-up communication style are described. A physician's initial communication style should include overall friendliness, asking the patient if they have questions or concerns, providing assistance with issues relating to the use of specific medications, giving clear instructions on how to take prescribed medication, clearly explaining how a medication may affect the patient and communicating to the patient the actions the patient can take on their own to feel better. Follow-up communication style includes the extent to which the physician encourages the expression of potential concerns or problems, asks about and listens

to those potential concerns, and helps to addresses those concerns in a helpful manner (Thompson & McCabe, 2012). The successful utilization of these provider communication strategies leads to effective patient activation, in which the patient is able to better understand the logic of treatment plans and, in turn, better participate in care (Alegría et al., 2013).

There is a clear power dynamic in the physician-patient relationship, with patients typically recognizing that they are less medically knowledgeable and thus entrusting their doctor with their health needs and not questioning them. If a physician is able to mediate that discord by way of clearly communicating with their patients on a consistent basis, there is more opportunity for trust to be established and maintained with a physician. Patient activation is a critical component of enhancing patient-provider communication and overall trust and quality of care (Alegría et al., 2013). When there is a sense of collaboration, as opposed to unilateral decisions being made by the physician, this makes for a more positive patient experience. Patients will be more inclined to trust the decisions made by their physicians when their physicians actively communicate and engage with them. Additionally, medical professionals can actively show their patients that their health matters to them by exercising compassion and sympathy, further enhancing opportunities to build a relationship of trust with their patients.

Compassion. Compassion can be measured by a physician's ability to "understand the patient's situation, perspective and feelings, communicate that understanding and check its accuracy, and act on that understanding with the patient in a helpful (therapeutic) way" (Bikker et al., 2017, p. 2). The benefits of compassionate care are improved clinical outcomes, increasing patient satisfaction with services, and promoting individual well-being and mental health (Strauss et al., 2016). Compassion is the combination of empathy and sympathy (Karadag Arli & Berivan Bakan, 2017). A patient's perception of their physician's empathy is an important

dimension of empathic engagement. Empathic engagement suggests that there is a reciprocal relationship between the physician and patient with regard to their shared "communication of understanding," and is a vital component of the fostering of a patient's trust in their physician (Hojat et al., 2017). When a person exhibits compassion, they are showing their capacity to truly appreciate the perspective of another person. In the healthcare realm, a physician demonstrates this by being in touch with the experiences of their patients and interacting in a manner that brings solace (Weiss Roberts et al., 2011). Compassion is a crucial characteristic that can enhance a patient-provider relationship when it is present and can be severely damaging when it is not. A physician's lack of compassion can lead to adverse health outcomes for the patient and a decreased sense of trust in their physician. Compassion is very important and without it, there is the potential for inadequate and incomplete care as well as decreased trust toward healthcare professionals.

On the other hand, it is important to consider the benefits of maintaining some sort of emotional distance to ensure that there is an appropriate balance of empathy and professionalism on the part of the physician. Excessive empathy may have the potential to impede on the quality of care if the physician is unable to separate themselves enough to have sound judgment. Thus, a bit of an emotional distance may be desirable not only to avoid an intense emotional involvement, but to reinforce the physician's personal durability in potentially emotionally-taxing situations (Dal Santo, Pohl, Saiani & Battistelli, 2013). Being able to understand a patient's experience without joining them in that experience is how to foster effective, patient-centered care and still keep an emotional barrier so as to make decisions without impaired judgment. The conscious understanding of how to control one's empathy towards someone else, particularly in healthcare, allows individuals to disentangle themselves from others, working to

avoid jeopardizing clinical outcomes of the patient due to excessive emotional involvement (Dal Santo, Pohl, Saiani & Battistelli, 2013). However, despite the risks of excessive empathy, promoting a positive relationship that includes the components of compassion, communication, and cultural competence is crucial to ensuring patient and physician engagement, activation, and trust.

People tend to trust individuals who treat them with compassion, and this translates to healthcare as well. Compassionate care yields positive results for patients, and for Latinx patients, it may be that the display of compassion positively influences their perceptions of trust toward their physician. The Latinx population is a minority group that is continually oppressed and mistreated, and it is possible that without understanding, or willingness to understand, from medical professionals, quality of care and levels of trust are compromised. The presence of compassion is seen to be key to many objectives of modern medical training, including improved communication skills, increased respect for the dignity and autonomy of patients, enhanced cultural sensitivity, and a mutually beneficial and reciprocal patient-provider relationship (Weiss Roberts et al., 2011).

Despite the healthcare field's understanding of compassion as an important factor of a patient's trust, a physician's training may be lacking in this area of teaching how to truly understand and empathize. Research suggests that there is less of an emphasis on the importance of empathy in the healthcare world and more of a shift toward cynicism, or a more singular focus on treating the actual illness or ailment, and not the person. There is a relationship between a physician's experience with health issues and the amount of compassion felt towards others; physicians who have struggled with their own health issues or health issues of a loved one endorse the connection between direct experience with illness and empathy (Weiss Roberts et al.,

2011). This is concerning when considering the number of medical professionals who do not fall into this category of having personal experience with illness but are still expected to show compassion to their patients, who come from all different types of experiences and backgrounds.

Cultural sensitivity. Culture plays a role in physician perceptions and treatment of patients. Bias and stereotyping exist among healthcare providers, even if at the subconscious level. In the broader historical and contemporary context, disparities in healthcare due to instances of prejudice and systematic bias are present and can affect subsequent care (Johnson et al., 2004). For instance, diagnostic variance, which refers to the notion that healthcare providers display variability in how they arrive at clinical decisions, can have a negative, often severe impact on patients, particularly when providers rely on racial/ethnic and gender stereotypes in clinical decision making and diagnoses (Hays et al., 2010).

There is little research on the specific role culture plays in patient outcomes and the technical aspects of treatments and procedures, but research does suggest that ethnic minorities, who are commonly in ethnic-discordant relationships with their healthcare professionals, commonly rate the quality of interpersonal care received more negatively than whites do (Johnson et al., 2004). To help bridge the gap between patient and provider, an understanding of how culture influences perceptions and quality of care must be met. This means that a certain level of cultural competence and sensitivity is essential in healthcare. For most definitions of cultural and linguistic competence, the requirements are that health care professionals adjust and recognize their own culture in order to better understand the culture of their patients (Johnson et al., 2004). When physicians are able to do this, the relationship between patient and physician has the potential to be improved as well as show better outcomes for patients. Understanding of a

patient's culture and values, especially if they are different than what the physician is familiar with, aid in the more holistic care of the patients and consideration of appropriate treatments.

Patient cultural characteristics and physician cultural bias have been investigated as a factor of diagnostic variance. Diagnostic variance is the notion that professional counselors or physicians display variability in how they arrive at clinical decisions, potentially resulting in differences in the amount and type of data that are collected from patients, varying interpretations of the same data among providers, and the differential application of criteria (Hays et al., 2010). For patients who belong to underserved populations, like the Latinx population, this tendency of physicians to rely on predetermined stereotypes can lead to inappropriate diagnoses and treatments of mental and physical conditions. Racial and ethnic minorities are more likely to perceive bias and an overall lack of cultural competence from their providers and the healthcare system as a whole than Whites (Johnson et al., 2004). The perception of both language and race/ethnicity related bias among minority populations is prevalent and significant as compared to the majority population's perceptions of the same type of care from their providers (Johnson et al., 2004). Thus, it is essential that providers be aware of how cultural factors relate to the care their patients receive in addition to how their patients perceive certain situations.

Previously studied interactions between patients and providers suggest that culture goes unnoticed or minimized by providers when working with their patients; however, a more overt awareness of cultural difference and how social injustice plays a role in the treatment and diagnoses of racial and ethnic minorities increases the likelihood of a positive prognosis for patients (Hays et al., 2010). In order to develop their own cultural competence, physicians should become aware of their own cultural identities as well as of the cross-cultural dynamics that exist

among the communities they serve (Hays et al., 2010). To treat everyone equally and be blind to the cultural differences that present themselves for each patient would be a disservice to those individuals, diminishing the quality of care they could receive if their provider had taken into consideration how these differences impact how such care should be approached.

Research shows that physicians should also take into careful consideration cultural match, which means how well their cultural identities match with their patients'. It may be easier for physicians to treat patients who have the same ethnic, gender, or socioeconomic identity as opposed to treating patients who come from different identities and backgrounds. When providers unintentionally disregard this cultural mismatch, particularly when the provider belongs to the majority population (e.g., White male) it can lead to a potentially less severe diagnosis for patients who match their culture or a more severe diagnosis for patients who do not match their culture (Hays et al., 2010). Problems with the diagnosis and treatment of mental health problems for racial/ethnic minorities in the primary care settings are particularly widespread, and improving this area of care could lead to increased utilization of available services and reduce these disparities (Blanchard & Lurie, 2004; Kohn-Wood & Hooper, 2014).

In looking at ways to develop cultural competence in the mental and primary healthcare realm, the United States Department of Health and Human Services, Office of Minority Health determined "Culturally and Linguistically Appropriate Services" that emphasize the areas of culturally competent care, language access services, and organizational supports for cultural competence as necessary components (Johnson et al., 2004). Institutions and providers are responsible for providing informed and inclusive care to their patients. This action would provide a framework for tailored intervention-models and improved diagnosis and treatment of Latinx patients and others who belong to minority populations (Blanchard & Lurie, 2004; Kohn-Wood

& Hooper, 2014). The Latinx population consistently experiences disparities in mental health care utilization and quality of care due to a lack of cultural understanding. This lack of understanding, in turn, has an effect on their desire to seek care with professionals they trust to put effort into understanding them, their cultural values, and background. A patient's positive perception of their provider's knowledge or willingness to learn about their culture and be sensitive to certain differences can have a positive effect on that patient's perception of trust toward their doctor.

Together, compassion and cultural sensitivity are characteristics that medical professionals must have to ensure the comfort and security of their patients. These concepts are related and must be used together in order to administer quality care. The expectation is that there will be an added effort from medical professionals in order to ensure the comfort and respect of their patients. Research suggests that there is a positive relationship between compassion and intercultural sensitivity, so increased compassion means increased intercultural sensitivity and vice versa. Taken together, these two constructs can be critical in promoting a patient's trust in their physicians, particularly for Latinx patients (Karadag Arli & Berivan Bakan, 2017).

Current Study and Hypotheses

This study is designed to provide more in-depth information on how patient characteristics and identity along with physician characteristics and skills relate to the perceptions of trust patients have toward their healthcare providers. Within the Latinx population, there are various factors involved in how doctor-patient interactions function, like language ability and preference and generational status. Latinx patients, like other minority populations, have unique needs and differences from the majority population that medical

professionals should be actively aware of and receptive to in order to provide the best care possible. There are few studies that examine the relationship between the racial/ethnic identity of Latinx patients in relation to their overall perceptions of trust toward their physicians. Previous research suggests that physician communication, compassion, and cultural sensitivity are predictors of how well physicians are able to promote a positive relationship with their patients in addition to improving overall health outcomes and adherence to treatment.

This study will use survey data from Latinx patients to delve deeper into the direct relationship between these patients and physician factors with regard to overall trust patients have with their providers. I hypothesize that cultural sensitivity, perceived compassion, and provider's communication ability will be positive predictors of perceived patient trust with their behavioral health or primary care provider. Language preference, generational status, and length of residence will also be related to the level of trust patients feel towards their provider. Participants' expectations for their physicians will also be analyzed through open-ended responses.

Method

Participants

An a priori power analysis was conducted using G*Power 3.1. Sample size was subsequently set at $N = 94$ to predict the outcome of trust using 7 predictors. This yielded a power of .75 to detect a moderate effect size ($f = .15$) at an alpha level of .05 for the linear multiple regression model.

88 Latinx adults participated in this study (M_{age}=33.1, SD=9.77). There were 24 male (27.3%) and 64 female (72.7%) participants. Of the participants, 72.7% were first-generation immigrants, 19.3% were second-generation immigrants, and 4.5% were third-generation

immigrants. Among the first-generation immigrants, length of residence in the United States was measured by range: 20.3% of the participants lived in the U.S. less than 6 years, 10.9% lived in the U.S. for 6-10 years, and 67.2% lived in the U.S. for more than 10 years. The participants were of Latinx background and primarily Spanish-speaking, so all materials were made available in both English and Spanish, and survey questions included questions addressing demographic identification.

Instruments

Demographics. Respondents answered four general demographic questions that asked their age, gender identification, race, and ethnicity. Participants' length of residence in the United States was also measured using a continuous, non-linear scale to account for the variability in responses. The three questions asked if the respondents were born in the United States, how long they have lived in the United States, and whether their parents were born in the United Sates in order to determine generational status.

English language preference (ELP). The three-question language preference survey was rated on a 5-point scale (1, English all the time; 2, English most of the time; 3, Spanish all the time; 4, Spanish most of the time, 5, English and Spanish equal) to assess how often a respondent prefers to think or speak in English or Spanish (Lueck & Wilson, 2010).

Trust in physician. A short version of the Wake Forest physician Trust Scale was used to measure respondents' perception of trust felt toward their provider. The five-item survey was rated on a 5-point scale (1, totally agree; 2, somewhat agree; 3, neither agree nor disagree; 4, somewhat disagree; 5, totally disagree) (Holwerda et al., 2013). Survey questions asked respondents to rate whether they felt their provider prioritizes their own interests above the patients', whether their provider is thorough and careful, whether the patient trusts their

physician's judgment of treatment, whether their provider is completely honest with them, and their overall feelings of trust with their provider (Holwerda et al., 2013). Inter-item reliability for this instrument was moderate ($\alpha = .62$).

Sympathy and Compassion. To measure sympathy and compassion, the 10-item Consultation and Relational Empathy (CARE) Measure was used with questions being rated on a 5-point scale (1, never; 2, rarely; 3, sometimes; 4, most of the time; 5, all of the time) (Bikker et al., 2017). This measure defines how the respondent rates the provider's ability to understand the patient's situation, perspective, and feelings, to communicate that understanding with the patient and check its accuracy, and to act on that understanding with the patient in a beneficial way (Bikker et al., 2017). The internal consistency for this instrument was good ($\alpha = .82$).

Communication. To measure patients' perceptions of their provider's communication abilities, questions from the communication domain of the Hypothesized Measurement Model of Interpersonal Care survey were asked (Stewart et al., 2007). The three-question survey addresses whether patients feel that their provider responds appropriately to the concerns that are elicited. Respondents were asked how often that type of care has been provided using a five-point scale (1, totally agree; 2, somewhat agree; 3, neither agree nor disagree; 4, somewhat disagree; 5, totally disagree) (Stewart et al., 2007). Inter-item reliability for this instrument was good ($\alpha = .86$).

Cultural Sensitivity. To measure cultural sensitivity, the Health Systems Bias and Cultural Competence Measures subscale of the Bias and Cultural Competence Survey were used (Johnson et al., 2004). This survey is designed to consider questions of a provider's respectfulness, level of cultural understanding, and acceptance of the respondent and his/her own life. The three questions were rated on a 5-point scale (1, never; 2, rarely; 3, sometimes; 4, most

of the time; 5, all of the time). General perceptions of bias and cultural competence are measured by a single question that assesses whether respondents believe the medical care they received would have been better if they belonged to a different racial/ethnic group (Johnson et al., 2004). Personal experience with racial/ethnic bias is measured by a single question, and a third question addresses whether respondents have felt that they have ever been judged unfairly or treated with disrespect based on their English-speaking ability (Johnson et al., 2004). Internal consistency for this instrument was good ($\alpha = .80$).

Open-ended question. Participants were asked if there was anything they would like to see more of from their provider. There was space provided for them to respond to this open-ended question.

Procedure

Participants were recruited from a legal aid office for Latinx immigrants in Canton, Ohio, and two primary care clinics in Southern California; they were notified of the survey by way of recruitment flyers posted in the three locations. The survey was distributed to the three locations by the researcher. The survey, which was available as a hard-copy, was completely anonymous and voluntary. It was also available in both English and Spanish. Surveys consisted of multiple-choice questions concerning the cultural sensitivity, sympathy/compassion, and communication aspect of the care the participants receive in addition to personal demographic questions and two optional short answer questions that allowed for the elaboration of their previous responses. At the end of the survey, there was an opportunity for participants to enter their name and phone number into a drawing for a gift card as compensation for their participation. At the legal aid office and two primary care clinics, the surveys were interviewer-administered by the researcher. For each location, data was stored and kept completely confidential, with completed surveys

stored in a secure area in the researcher's possession. Once research concluded, data was stored in the locked cabinet of the researcher's library carrel.

Results

The means, standard deviations, and interrelationships of all the variables in the study are shown in Table 1.

Predicting Trust

To determine the predictors of trust, a hierarchical regression was run. Two models were used to determine how the ways in which they differentiated predict trust. In the first model, individual patient characteristics were examined to determine their predictive relationship of trust. In the second model, physician characteristics now controlling for perceived individual patient characteristics were analyzed (Table 2).

In Model 1, there were no individual characteristics (i.e., age, generational status, language preference, and length of residence) that predicted trust in the sample of Latinx individuals. In Model 2, when controlling for the individual characteristics, age became a predictor $b = -.29$, $p < .05$. The older a patient is, the more trust they feel towards their physician. The only perceived physician characteristic that significantly predicted a patient's level of trust was compassion $b = -.74$, $p < .001$. The more compassion a patient perceives from their physician, the more trust they have in their physician. Model 2 explained 61% of the variance of trust, making it a significant model.

Expectations for Physicians

Of the 88 participants, 15 (17%) provided a response to the open-ended question of whether there was something they would like to see more of from their provider. These responses were analyzed using thematic analysis (Corbin & Strauss, 2008). The responses were

read multiple times by the researcher, each time coding for commonalities across the data. Those commonalities represent the themes within the data. There are three main areas that patients identify as areas of potential improvement provide a more detailed look at what the healthcare industry can work towards to improve the physician-patient relationship of trust.

The first theme was that patients would like for their doctors to have more available appointments and for their doctors to seem more willing and open to discuss patient concerns. Surveyed patients said that "more availability for appointments" would aid in improving their relationship with their doctor. One patient stated that "[my doctor should] show that she cares, not just give me what I ask if she wants to," suggesting that their doctor focuses solely on the medical details of the visit as opposed to being more personable and attentive to the patient's feelings and concerns.

The second major theme is that patients would like for their doctors to be more attentive to the details of their care and more thorough in treating them, with the doctor asking questions when necessary and moving beyond just simply carrying out the expected tasks of their job. One patient said that "They [doctors] should also be more tolerant with patients who are older and pregnant. [They should] let them know the risks and the options and improve their tone in presenting that information. [They should be] more sensitive, patient, and calm."

The third major theme is that, especially for those who have recently immigrated to the United States, patients perceive their lack of health insurance as a detriment that affects how well they are treated by their doctor and the quality of care they receive. One participant explained how he had experienced negligence while seeking care. His doctors did not believe the severity of his injuries. He frequently gets hurt due to work-related injuries and does not have insurance to cover treatment of those injuries. In one example the participant provided, he had gotten metal

in his eye and when he went to get treated, the first person who examined him did not believe he really had metal in his eye and wanted to just give him a prescription for eye drops. It was not until another doctor intervened that it was confirmed that he had an injury that needed to be treated.

Another participant emphasized the point that treatment is not guaranteed, especially if the individual does not have insurance. This participant had taken her sick daughter to be seen by a doctor and the facility turned them away because she did not have insurance and could not cover the cost of the medical visit. In addition, there is often an added language barrier that complicates the interactions patients have with their physicians and other healthcare professionals and few resources that address this barrier. Many of the respondents indicated that they were trying to learn English, but even this effort is not always enough. One respondent said, "The language barrier is a constant issue. [Especially] when they don't understand Spanish it can be difficult. They do an okay job here (Ohio) trying to have resources and translators." However, not every clinic or hospital has the necessary resources to address the needs of their patients who do not speak English as their primary language.

Discussion

The presence of trust is critical for a positive physician-patient relationship. Being aware of individual patient characteristics like age, language preference, and generational status can and should have an influence on the approach physicians take to treat their patients. In addition to the individual differences among patients, it is also important to note that physician characteristics and skills can have a significant impact on a patient's perceived level of trust and overall comfort with their doctor. The results reveal that Latinx participants noted the presence of compassion from their physician as the most important factor in fostering a relationship of

trust. When physicians exhibit compassion, patients feel an increased sense of trust toward their doctor. This idea is expanded upon in many of the qualitative statements in which participants stated that they wished that their doctor would show more patience, sensitivity, and calmness. Additionally, when examining the relationship between age and perceived trust, it was the older Latinx individuals who reported higher levels of trust in their physician.

Trust, Compassion, and Age

A physician's level of compassion and ability to show care for their patients is essential for a positive physician-patient relationship to be fostered. Compassion was the only significant physician characteristic positively predicting a patient's perceptions of trust in their doctor. Trust is something that has to be earned, and by showing compassion, establishing trust is more likely. When a physician listens to and understands a patient's concerns, provides complete and honest information, and acts in the patient's interest, trust is more easily accomplished as a result (Thom, Hall & Pawlson, 2004).

Although the population examined was completely comprised of Latinx participants, the finding that compassion is an important factor for patients in establishing a positive relationship with their doctor and the overall healthcare field coincides with similar studies' results, even with ethnically diverse populations (Alegría et al, 2013; Hojat et al., 2017). A patient's perception of their physician's compassion is an important dimension of empathic engagement, and when present, this suggests that there is a positive reciprocal relationship between the two parties with regard to shared understanding (Hojat et al., 2017). In the healthcare realm, a physician demonstrates their compassion by truly appreciating the perspective of another person and by being in touch with the experiences of their patients and interacting in a manner that brings solace (Weiss Roberts et al., 2011). With compassion being a positive predictor of a

patient's perception of trust in their provider, it can be concluded that most of the Latinx participants felt that their physicians, many of whom belong to a different ethnic group, did well to consider the experiences of their patients and interact with them in a comforting and caring manner.

In addition to compassion, the patient characteristic, age, was also a predictor of trust. Older Latinx patients who had an increased sense of trust in their doctors. There are many possibilities for why this was the case, such as the traditional ideas of respecting one's superiors or trusting people in power (Caballero, 2011). Older Latinx adults might be more sensitive to the demands of family and remaining healthy in order to provide for their family (Caballero, 2011). This demand to take control of one's own health, in turn, provides more opportunities for the older Latinx adults to establish and foster these positive relationships with their physician, increasing trust. Language and generational status could have also played a role. Excluding the responses from the recently immigrated individuals, it was primarily the older adults who spoke only or mainly Spanish. This language difference between physician and patient may have contributed to the increased feelings of trust because they may feel that they have no other real option than to trust the judgment of the trained professional who is caring for them.

Additional Physician Characteristics and Trust

Despite the lack of a statistically significant relationship between a physician's language, cultural sensitivity, and communication ability with trust, it can still be argued that these are critical components of a successful working relationship between a patient and their physician. The connection between a physician's good communication and cultural understanding of their patients highly influences perceptions of the health care system as a whole, the manner in which prescribed regimens are applied, and overall health outcomes (Majumdar et al., 2004).

The expected relationship between cultural sensitivity and trust may not have been present because of the positive cultural representation that was evident in the surveyed areas, particularly the Southern California clinics that are commonly equipped with resources to address the needs of Latinx patients. Cultural sensitivity is still an important skill that physicians should have when having to interact with and treat patients of various different backgrounds. Cross-cultural education and trainings of medical professionals would prove beneficial and increase patients' perceptions of trust in the medical professionals who care for them. Cultural sensitivity trainings should include a few key content areas: general cultural concepts, racism and stereotyping, physician-patient relationships, language, specific cultural content, access issues, socioeconomic status, and gender roles and sexuality (Johnson et al., 2004). Building on this framework as a guideline for providing culturally sensitive care could improve patients' overall perceptions of care and feelings of trust.

Similarly, the expected relationship between communication and patients' perceptions of trust may not have been as significant for various reasons. The survey questions ask more about the expression of thought and seriousness of concerns on the part of the doctor. Perhaps questions speaking to language and the clarity of physician communication would have indicated a different relationship between communication and a patient's perceptions of trust toward their physician. Communication and language ability work together to provide effective care. When considering the Latinx population and a physician's communication ability, language and being able to communicate in the same language as their physician is of particular importance, as previous studies and especially the qualitative analysis of this current study elucidate (Alegría et al., 2013; Thompson & McCabe, 2012).

There was no statistical significance found when analyzing a physician's communication and cultural sensitivity as it relates to Latinx patients' perceptions of trust. This lack of significance may not be a question of the validity of the constructs that were used to measure cultural sensitivity, communication, and language, but rather a question of the population's customs and understanding of interactions where an evident hierarchy of power is present. Even if this power is not misused, the doctor-patient relationship is a sensitive one and the doctor must take into account several factors about their own positionality and that of their patient in order to administer the best, most appropriate care possible. For patients, there is never any real indication that they should not have complete trust in their doctor, so calling into question specific aspects of their physician's skills and characteristics may be counterintuitive. However, as healthcare institutions move forward to consider how to best meet their patients' needs, these factors and skills must be implemented into trainings in order to allow for self-reflection and improved physician-patient relationships.

Implications of Qualitative Analysis

The qualitative responses were used to expand on the survey answers. Participants provided detailed responses to the question of whether there was anything they would like to see more of from their doctor with regard to the care they receive. These detailed answers (Appendix A) explain both the positive and negative experiences and interactions Latinx patients have had with their doctors. These accounts suggest that there are identifiable areas of improvement; however, the survey responses indicate that compassion and age were the two most influential variables to have a direct impact on a patient's perceptions of trust in their physician.

There are both verbal and non-verbal physician behaviors that have positive associations with health outcomes (Tucker et al., 2003). These include compassion, friendliness, time, and

courtesy. In interpreting the responses to the open-ended question, there is an apparent trend that these behaviors are important to how patients perceive their relationships with their physicians and the healthcare industry as a whole. Respondents note a physician's availability and obvious interest in making time for their patients are critical to feeling comfortable and happy with the service they receive. In the negative interactions that patients recalled, the most repeated response is that the patient would like to see that their physician is genuinely expressing their care and concern and is actively engaged, focusing only on the patient's needs during the scheduled visit. Many of the older participants were the ones who provided a response to the optional open-ended question, possibly indicating that there are areas outside of the survey questions that they would like to see improvements in.

These detailed responses illuminate specific areas of focus with regard to what physicians and healthcare institutions can work on to improve overall care and trust in addition to highlighting areas that are currently working well and offering a space to enhance those areas. These responses can also inform future qualitative research on this topic.

Limitations and Future Directions

The results of this study should be interpreted while considering several limitations. The scope of this study is focused on how patient and physician characteristics contribute to feelings and perceptions of trust in primary healthcare settings. Expanding this research to other healthcare institutions would be of use in order to more clearly show where areas of improvement could be focused. The study was conducted at two primary care clinics in Southern California and a legal aid office in Canton, Ohio. In order to survey a larger and more representative sample, particularly with regard to gender and age, surveying participants from more locations in multiple different geographical areas over a more extended amount of time

would provide the opportunity to find stronger statistical significance of results as well as more concrete trends.

Additionally, the structure of survey questions and translation from English to Spanish may have confused participants and been interpreted differently than expected. A few respondents asked the researcher to clarify the meaning of some of the questions, indicating that the survey was not universally understandable for each participant. Use of a qualified translator and pilot testing of the survey before distribution could eliminate the potential for misunderstanding of questions in addition to providing beneficial patient input, particularly because the survey is intended to garner responses from a population with diverse opinions and experiences.

In addition to the structure of survey questions, the length of the survey may have been an additional deterrent. Although questions were fairly short and straightforward, the sheer length of the survey may have impacted how genuinely participants responded throughout the entirety of the survey. As previously mentioned, using pilot participants as a trial for the actual survey could be useful in terms of identifying areas that may require modification in order to receive the most accurate and in-depth responses possible.

Conclusions

The importance of patient-defined, culturally sensitive, compassionate care is evident, particularly among minority populations like the Latinx community. The United States is becoming increasingly diverse and there should be appropriate resources within the health realm and beyond to address the growing differences, expectations, and abilities of the people who reside in this country. It is important for future research to explore the impact physician characteristics in conjunction with patient characteristics can have on how well a patient is

actually being served and whether they feel the treatment meets their needs. Working towards a patient-centered approach in healthcare would greatly improve the perceptions of trust patients have toward their physicians and the overall health outcomes of those patients. It is clear that compassion is one of the key factors that contributes to the Latinx population's feeling of trust in their physician, but cultural sensitivity and language ability, the two other studied characteristics, should be considered as equally important in fostering a relationship that builds trust. A physician's ability to take the time and effort to understand the patients they serve and learn what they can in an organized setting to administer the best care possible would yield positive results in terms of care, adherence to treatment, and overall feelings of trust.

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Table 1

Correlations among Variables

Variables	1	2	3	4	5	6	7	8
1. Trust		-.69***	.30**	.37**	-.30**	-.08	-.27*	.01
2. Compassion			-.29	-.42**	.14	.09	.32**	-.08
3. Communication				.15	-.08	-.12	-.05	-.08
4. Cultural Competency					-.11	-.00	-.22	.04
5. Age						.08	.58**	-.05
6. Generational Status							.20	-.60**
7. Length of Residence								-.32*
8. Language Preference								
M	1.63	4.52	1.73	1.38	33.01	1.29	2.54	3.60
SD	.58	.55	1.02	.76	9.77	.55	.79	1.27

***$p < .001$, **$p < .01$, *$p < .05$

Table 2

Hierarchical Regression Analysis Predicting Trust

	Model 1			Model 2		
Variable	*B*	*SE*	*β*	*B*	*SE*	*β*
Intercept	2.17***	.79		5.07	1.10	
Age	-.02	.012	-.25	-.02	.01	-.29*
Generational Status	.15	.22	.12	.14	.17	.11
Language Preference	-.03	.10	-.05	.03	.07	.06
Length of residence	.01	.19	.02	.15	.14	.16
Cultural Competency				-.11	.10	-.15
Compassion				-.76	.16	-.74***
Communication				.04	.10	.05
Provider Language				.03	.23	.02
R^2		.08			.61	
F		.83			6.48***	
ΔR^2		.08			.53	

***$p < .001$, *$p < .05$

Appendix A

Question 1 – Is there something you would like to see more of from your provider?

1. Dr. Solinas basically saved my life 10 years ago. She is very thorough and careful and I owe my health to her today.

2. More availability for appointments

3. More available appointments when needed

4. More available appointments when needed

5. Show that she cares, not just give me what I ask if she wants to.

6. The reminder calls cut off sometimes and it doesn't let you call back, sometimes it takes a long time for anyone to answer when they put patients on hold. They should also be more tolerant with patients who are older and pregnant. Let them know the risks and the options and improve their tone in presenting that information. More sensitive, patient, and calm. I gave a complaint to the manager and she treated me well, but the front office staff mistreated me, their general courtesy was lacking.

7. More of a thorough assessment

8. It could be a little bit better. More attention paid to details of the patient.

9. Insurance is their priority and it has changed a little bit now because I have a good relationship with my doctor. But at the beginning, it was not good. Papers are important, and legality is important. It takes too long for them to trust me and take my concerns seriously. They almost treat it like an interrogation where they ask if that is my real name and if I'll actually pay my medical bills. Sometimes feels like they do that because they don't want to treat me with expensive thigs in case I don't pay.

10. Had bad experiences of negligence before. People not believing the severity of his injuries. He gets hurt a fair amount due to work-related injuries and gets bad treatment because he does not have insurance. Once got metal in his eye and went to get treated and the first person who checked him did not believe he really had metal in his eye and wanted to just give him drops and it wasn't until another doctor came over and actually checked that it was confirmed that he had an injury. He tries to avoid going to the doctor due to the negligence and not having insurance.

11. Idea that not having insurance does not guarantee you care, happened to her/her daughter in Maryland when her daughter was really sick, and they got turned away. Language barrier is a constant issue, when they don't understand Spanish it can be difficult. They do an ok job here (Ohio) trying to have resources and translators.

12. The doctor needs to have patience with their patients

13. Treat and care for their patients better. Attend to their patients better. (Atender bien a los clientes)

14. I do not have insurance

15. Provide better/more options for medicine when I feel bad (Dar mejor/más opciones sobre medicamento cuando siento enfermo)